Valley Mill Camp
Registration for City of Falls Church
www.valleymill.com

15101 Seneca Road, Germantown, MD 20874 (301) 948-0220

Name_____**Nickname**_____**Boy**_____**Girl**_____

Street_____

City_____**State**_____ **Zip**_____

Home Phone_____**School**_____

Grade Next September_____**Age**_____**Date of Birth**_____

Work Phones (1)_____ **(2)**_____

e-mail (1)_____**(2)**_____

Alternate to call if parent cannot be reached:
Name_____

Address_____

Phone_____ **Other phone**_____

Family Physician_____**Phone**_____

Date of last tetanus shot (mo/da/yr)_____
Allergies_____
T-shirt size: Child S M L Adult S M L XL

Parent Signature_____**(1)Cell:**_____

Print Name_____ **(1)**

Parent
Signature_____**(2) Cell:**_____

Print Name_____**(2)**

Valley Mill Camp Health Form

Child's Name_____ DOB_____ Sex____ Age ____
Parents or Guardian _____ Home Phone:_____
Work Ph (m): _____ Work Ph (d):_____
Cell Ph(m): _____ Cell Ph (f): _____
Home Address _____
Business Address_____
Parent 1 Email(s) _____Parent 2 Email_____
Emergency Contact (if parent or guardian cannot be reached): _____
Phone Numbers: Home: _____ Work: _____
Cell: _____
Family Physician (required): _____
Phone (required): _____
Date of last physical exam ___/___/___
Health History (check all that apply to your child, give details if necessary)
__ Frequent Ear Infections __ Heart Condition __ Mononucleosis __ Seizures __ Diabetes
__ Head injury __ Bleeding/Clotting Disorder __ Asthma __ Psychiatric Treatment
__ Other_____
Does your child have any significant or chronic medical conditions? If yes, please describe:
_____
What medications does your child take at home?
_____
What medications* will your child need to be taking at camp? (Physician/Parent signed medication form is required)

*** Please note: CONTROLLED SUBSTANCES--ie Ritalin, etc--taken by campers, must be DRIVEN to camp and may NOT be brought in on the bus.**

Vaccines/Diseases (Check all that apply)
__ Chicken Pox __ Measles __ German Measles __ Mumps __ Hepatitis __ Other _____

Other Health Information: Please provide information on any medical conditions, psychological conditions, behavioral conditions, dietary restrictions, allergies, limitations, or special needs that we need to be aware of to ensure that your child has a positive experience at camp.
_____
_____
_____

Allergic Reactions (Check all that apply)
__ Hives __ Anaphylaxis __ Nausea __ Trouble Breathing __ Itching __ Local Swelling
Other:
_____
_____

Valley Mill Health Form Continued- Page 2

Camper's Name:_____

1. **PRN Medications: I give permission to Valley Mill Camp Staff to Administer the following medications to my child as needed (please check all that apply):**
   ____ Tylenol ____ Motrin/Advil ____Benadryl _____Other
2. **Insurance Information:**
   Is your child covered by family medical/hospital insurance? □ Yes □ No
   If so, carrier of Plan Name _____ Group # _____
3. **Camper Immunization Information See: www.EDCP.com**
   Provide date (month/year) of child's last Tetanus shot (DTP) (do not leave blank) _____
4. **Is your child attending a Maryland School private or public?**

□ **If Yes: Provide the name of the Maryland school:_____**

□ **If No: If your child is attending a school outside of Maryland, please attach a record of immunizations signed by a doctor confirming that the child has received all immunizations as required by Maryland DHMH, Recommended Childhood Immunization Schedule. See: www.EDCP.org for immunization information.**

5. **Is your child exempt from any immunizations on medical, or religious grounds?**

□ **If Yes: Provide a copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.**

□ **If No: Please describe any limitation or restriction on your child's camp activities:**

_____

This history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. This completed form may be photocopied for trips out of camp.
Signature of parent/guardian _____ Date ___/___/___

I understand and agree to abide with any restrictions placed on my camp activities.
Signature of camper _____ Date ___/___/___

Please report any changes in your child's health to the camp nurse in writing.
Keeping the camp well informed will help our staff give the best possible care to your child.

Thank You.

Valley Mill Camp Medication Form

To be filled out only if camper will be taking medication on camp property

Part One
To be completed by the Parent

I hearby request and authorized Valley Mill Camp personnel to administer prescribed medication as the physician prescribes. I agree to release, indemnify and hold harmless any and all Valley Mill Camp Staff members from any lawsuit, claim, demand or action, etc., against them for administering prescribed medication to this camper, provide that Valley Mill Staff are following the physician's order as written in Part Two below. I have read the procedures outlined in this form and assume the responsibilities as required.

Camper_____
Birth Date_____
Prescription_____ Renewal_____ New_____
If New, the first full day's dosage was given at home on_____
List all medication(s) your child is taking (over the counter medications included):
_____
_____
_____

_____ _____
Parent Signature Date

Part Two
To be completed by a Physician

Any medication which possibly can be administered before or after camp should be so prescribed. Valley Mill Camp will administer medication when absolutely necessary.

Camper_____
Diagnosis_____
Medication_____
Dosages and time(s) to be given at camp:
_____
If PRN, specify when indicated:_____
Route of Administration_____
Effective dates from:_____to_____
Side effects:_____
_____
Physician's Name (print or type)_____
Physician's Phone Number_____
Physician's Signature_____